AHCCCS CLAIMS CLUES

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CLAIMS FOR DURABLE MEDICAL EQUIPMENT
For Dual Eligible Members
Monthly vs. Daily Units of Service

Durable Medical Equipment (DME) suppliers submitting claims to both Medicare and AHCCCS for services provided to dual eligible members should submit those claims with all dates of service for that equipment to receive full payment.

AHCCCS usually pays for rental of Durable Medical Equipment (DME) on a daily rental rate. Claims must include the entire range of dates that the DME was provided for the DME supplier to receive payment for all those dates of service.

Medicare usually pays for DME on a monthly basis, regardless of how many days during that month the beneficiary actually needed or used the equipment. DME suppliers may list all dates the member used the equipment, but need only submit the claim with a single date of service to receive payment for the entire month's rental rate.

Claims for DME with a single date of service submitted to both Medicare and AHCCCS (or its Contractors) results in payment of a full month's rental rate by Medicare but only the co-pay for a single date of service from AHCCCS. To receive proper payment for all days, the DME supplier must then need to submit a revised claim to AHCCCS with all relevant dates of service.

To eliminate the need for filing revised claims to receive payment for all dates of service, DME suppliers billing Medicare and AHCCCS for dual eligible members should submit the initial claim to both payors with all relevant dates of service. This will result in the same monthly payment from Medicare, but will allow for proper payment for all dates of service by AHCCCS or its Contractors.

BILLING FOR BILATERAL PROCEDURES

AHCCCS's current (prior to 1/1/2008) policy requires providers, both Professional and OPFS, billing for Bilateral Procedures to bill this service in two lines – one with the modifier and 1 without (see the example below).

Line 1 of the claim – Procedure 00000, no modifier, 1 unit, full charges
Valuation – 100% of AHCCCS fee schedule
Line 2 of the claim – Procedure 00000, with a "50" (bilateral service) modifier, 1 unit, full charges
Valuation – 50% of AHCCCS fee schedule

Modifier "50" is currently (prior to 1/1/2008) loaded in the AHCCCS Claims system as allowing at 50% of the AHCCCS fee schedule.

Medicare and commercial billing rules require the provider to bill this service as a single line with the "50" modifier and the appropriate # of units (see the example below).

Line 1 of the claim – Procedure 00000, with a "50" (bilateral service) modifier
Valuation – 150% of fee schedule

The inconsistency between AHCCCS policy and Medicare/Commercial Insurance has caused numerous complaints from Hospital providers under the new OPFS methodology as well as inconsistent and erroneous billings.

AHCCCS is therefore modifying our current billing policy (for both Professional and OPFS) in relation to bilateral procedures to be consistent with Medicare/Commercial Insurance, **EFFECTIVE for dates of service on or after 1/1/2008.**

Ambulatory Surgery Center (ASC)

Although CMS is changing its Ambulatory Surgery Center (ASC) payment methodology and adding codes for services that may be performed in, and eligible for payment at ASCs effective 1/1/2008, AHCCCS will not be making those changes for January 1. AHCCCS is currently in the process of analyzing ASC payment structures and the operational impact of opening new codes for payment. AHCCCS will not be making changes to ASC allowed codes or payments until mid-to-late 2008. Questions may be addressed to Jean Ellen Schulik at JeanEllen.Schulik@azahcccs.gov.

MANDATORY CLAIMS AUDITS – COMING SOON

Payment Error Rate Measurement or PERM is a mandatory Quality Control audit required by the Centers for Medicare and Medicaid Services (CMS) due to the Improper Payments Information Act (IPIA) of 2002. The State of Arizona will be required to participate in PERM for the Federal Fiscal Year of 2008 which begins October 1, 2007 and ends September 30, 2008 and every three years thereafter.

The State is required to provide the universe of all paid claims on a quarterly basis to a statistical contractor who will select a random sample of claims from the universe to review. The first universe for October through December claims will be submitted January 15, 2008. We anticipate receiving the selected sample in February. If a provider has claims selected in the sample, they will receive a letter from AHCCCS stating that they have claims which have been selected for PERM review.

The sample will then be provided to a data gathering contractor, Livanta, who will be sending the provider a letter, requesting all medical documentation be submitted back to Livanta within sixty (60) days. If the documentation is not provided within the sixty-day timeframe, the claim will count as an error for the state. If partial documentation is received, the sixty day timeframe stops and if more documentation is needed a new request for documentation will be sent allowing only fifteen (15) days to provide the necessary documentation. It is important that you keep this information updated and your staff informed of this procedure so that the proper medical documentation is sent within the required timeframes.

A third contractor, Health Data Insights, will conduct the claims reviews. All three contractors have been contracted by Centers for Medicare and Medicaid Services so therefore you do not need to be concerned with providing them patient information as long as it is sent to them in a secure fashion (i.e. secure e-mail).

Should you have questions regarding this upcoming audit, you may contact Kyra Westlake at kyra.westlake@azahcccs.gov.

ABDOMINAL EXPLORATION AS A SEPARATE PROCEDURE

AHCCCS has received complaints regarding our denial of claims for services billed under CPT code 49000 ("exploratory laparotomy, exploratory celiotomy with or without biopsy(s) (separate procedure)") when billed with other intra-abdominal procedures. We have reviewed this and for the reasons cited below reaffirm our position that this is not a separately payable service when performed with other intra-abdominal procedures.

Rationale – The Centers for Medicare and Medicaid Services (CMS) in coordination with the Correct Coding Initiative (CCI) has developed lists of Current Procedural Terminology (CPT) codes that cannot be billed together. These are commonly referred to as CCI edits. In the case of CPT code 49000, that code is listed with all other CPT codes that describe intra-abdominal procedures. In other words, it is considered to be a part of every specific abdominal procedure and cannot be paid for separately when combined with any of those procedures. If performed alone, rather than in combination with another intra-abdominal procedure, then it may be billed separately.

Some providers have claimed that when the exploratory laparotomy is necessary due to trauma then it should be paid as a separate service. If an abdominal exploration is necessary in a trauma case and no specific repair or other procedure is performed during that exploration, then CPT 49000 is the appropriate code. However, if another procedure or procedures are performed during the exploratory procedure, then only the specific procedure codes may be billed and the exploration is considered a part of those procedures. This is true whether the case is an elective abdominal exploration or an emergency procedure necessitated by trauma to the patient.

Should you have questions or concerns regarding this article, you may contact Marc.Leib@azahcccs.gov.

CLAIMS EFFICIENCY TIPS FOR PROVIDERS

CLAIM SUBMISSION –

Electronic Claim Submission –

AHCCCS strongly encourages providers to submit HIPAA-compliant 837 electronic claims. Providers and Clearinghouses must successfully complete testing to be certified to submit 837 transactions. For assistance establishing this process, you may contact AHCCCS Customer Support Center at 1-800-417-4451. Providers will need to submit (hardcopy) of Medicare or Other insurance Explanation of benefits if claim requires.

Web submission of claims –

AHCCCS allows and encourages providers to submit Professional, Institutional and Dental claims via the AHCCCS website. Go to https://azweb.statemedicaid.us. AHCCCS registered providers will need to establish a username and password for login purposes if you have not already established one. Providers will need to submit (hardcopy) of Medicare or Other insurance Explanation of benefits if claim requires.

Manual (Hardcopy) claims submission –

- All claims submitted must be legible and submitted on the correct and current version form type for the type of services being billed.
  CMS 1500 (08/05) version - Red and White is preferred
  UB04 – Red and White is preferred
  ADA2006

Please note – if the current versions of the forms are not used – the claim will be returned to the provider.

- Claims should never contain highlighter or Liquid paper correction
- Claims should be mailed to
  AHCCCS fee for Service Claims
  P O Box 1700
  Phoenix, AZ 85002-1700

SUBMITTING MEDICAL RECORDS TO AHCCCS –

Medical Review is a function of the AHCCCS Claims Department and is performed to determine if services were provided according to AHCCCS policy, particularly related issues of medical necessity, emergency service and outlier review.

In an effort to assist AHCCCS in identifying and “linking” submitted records to the appropriate claim, providers are encouraged to use the attached (see Exhibit 1)

cover sheet when submitting Medical Records to the Claims Department. This form should be sent to the AHCCCS Claims Department as indicated on the form. Records can be attached to one CRN only – do not expect records to be attached to several CRNs.

CLAIMS CORRECTION REQUESTS –
Providers are encouraged to use the Claims Correction Request Form (see Exhibit 2) to correct many common errors without resubmitting the claim. This form may be faxed to the AHCCCS Claims Research Unit at 602-417-4430. The completed Claims Correction Request Form must include the provider's name and ID #, a contact person's name SIGNATURE and date the request was sent. Do not use this means to submit Medical Records.

RESUBMISSION OF CLAIMS –
If the provider chooses to submit a "new" or "corrected" version of a previously submitted claim, **the original AHCCCS Claim Reference Number (CRN) must be included on the resubmission** (in BLACK ink) to enable the AHCCCS system to identify the claim being resubmitted. Otherwise the claim will be entered as a new claim and may be denied for being received beyond the initial submission time frame. Providers do NOT need to resubmit documentation unless specifically requested to do so. Mark the claim being resubmitted clearly with "RESUBMISSION" in BLACK ink. For consistency purposes, indicate the original CRN in

- Field 22 (Original Ref. No) on the CMS 1500
- Field 79 (Remarks) of the UB04 form – (be sure to use XX**7** bill type)
- Field 35 (Remarks) of the ADA form

Resubmissions can also be done using the web transmission of claims.

(Exhibit 1)

TO: AHCCCS Claims
P O Box 1700
Phoenix, AZ 85002

Medical Documentation

CRN:_____

DOS:_____

Comments:

_____

_____

_____

From: _____
Date:_____

CLAIM CORRECTION REQUEST FORM

Provider Name:		AHCCCS Provider ID #:		Provider Representative:	

Please complete one request form for each Provider ID.

Recipient's name:	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Fields to be Changed / Comments / Questions:**		
Recipient's name	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Fields to be Changed / Comments / Questions:**		
Recipient's name	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Fields to be Changed / Comments / Questions:**		
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CRN:	**Fields to be Changed / Comments / Questions:**		
Recipient's name	**Recipient's AHCCCS ID:**	**Dates of service:**	**Billed amount:**
CRN:	**Fields to be Changed / Comments / Questions:**		

This is to certify the information submitted and changes listed/requested on this Claim Correction Request Form are true, accurate and complete. I understand that payment of this claim will be from Federal and State funds, and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.		**Date**
Signature of Provider Representative (Required):		